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Medicaid Prior Authorization
Web PA
Help
Welcome to Web PA
Please Log In or Register To Use
Login
User Name
Password
Login
Register to use this site
Forgotten password help
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Wisconsin Department of Health and Family Services


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Forgotten Password Help
Fields in blue are required.
Please enter your User Name, then press Get Password Reminder.
User Name
Clear
Get Password Reminder
Release-2005-MARCH-1.10-prd
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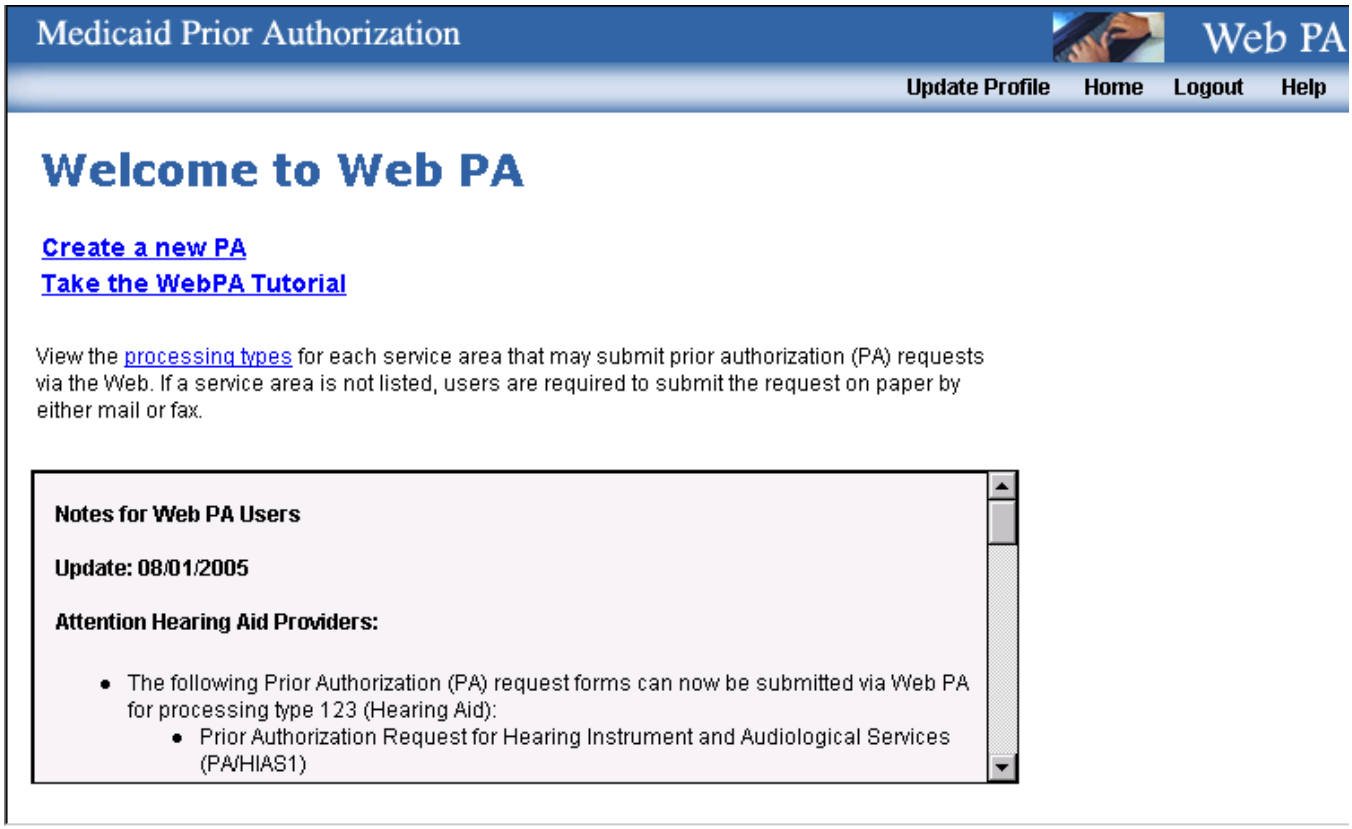
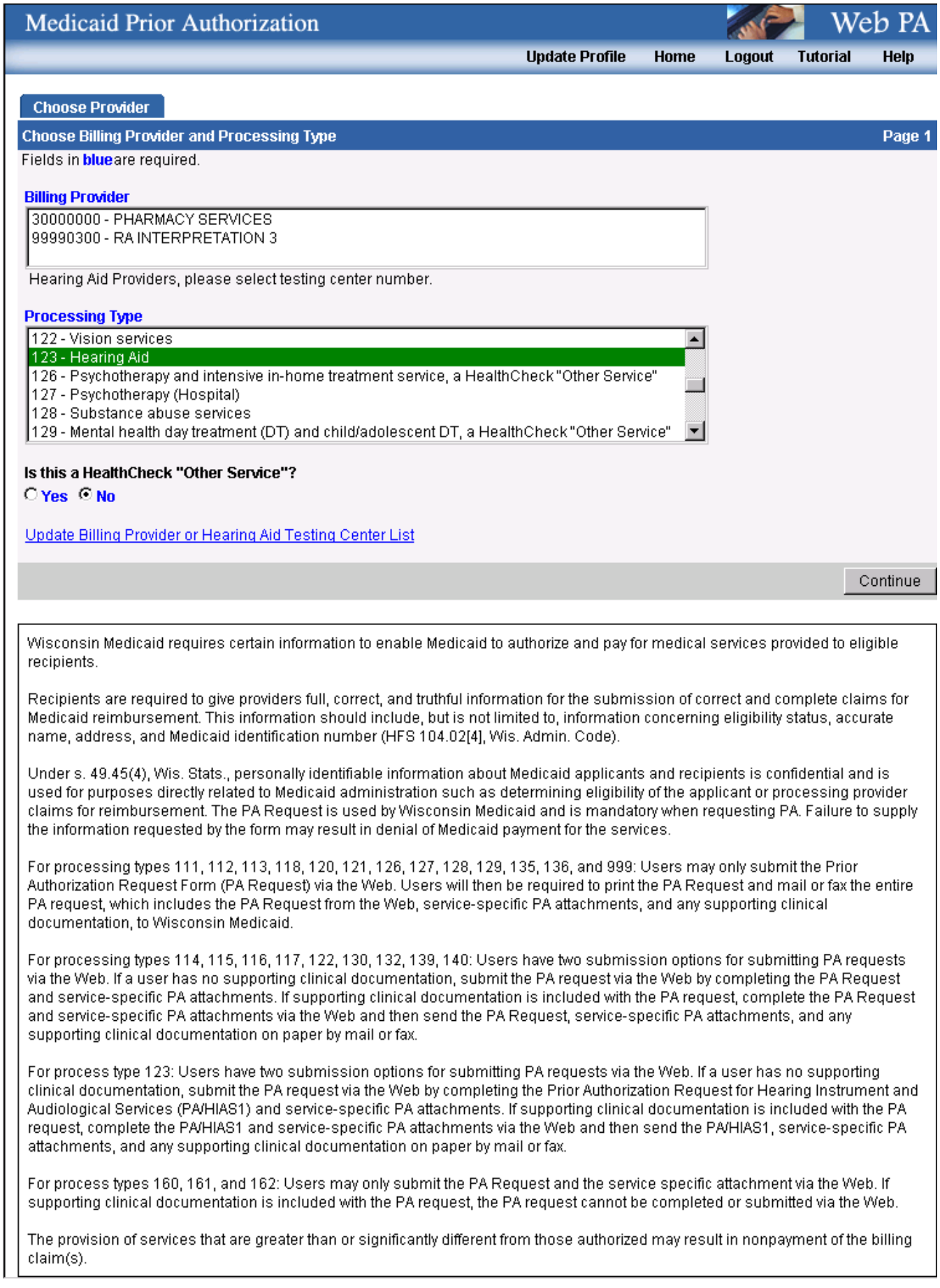
Wisconsin Department of Health and Family Services


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Help
Welcome to Web PA
Create a new PA
Take the WebPA Tutorial
View the processing types for each service area that may submit prior authorization (PA) requests via the Web. If a service area is not listed, users are required to submit the request on paper by either mail or fax.
Notes for Web PA Users
Update: 08/01/2005
Attention Hearing Aid Providers:
The following Prior Authorization (PA) request forms can now be submitted via Web PA for processing type 123 (Hearing Aid):
Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1)




Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The PA Request is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

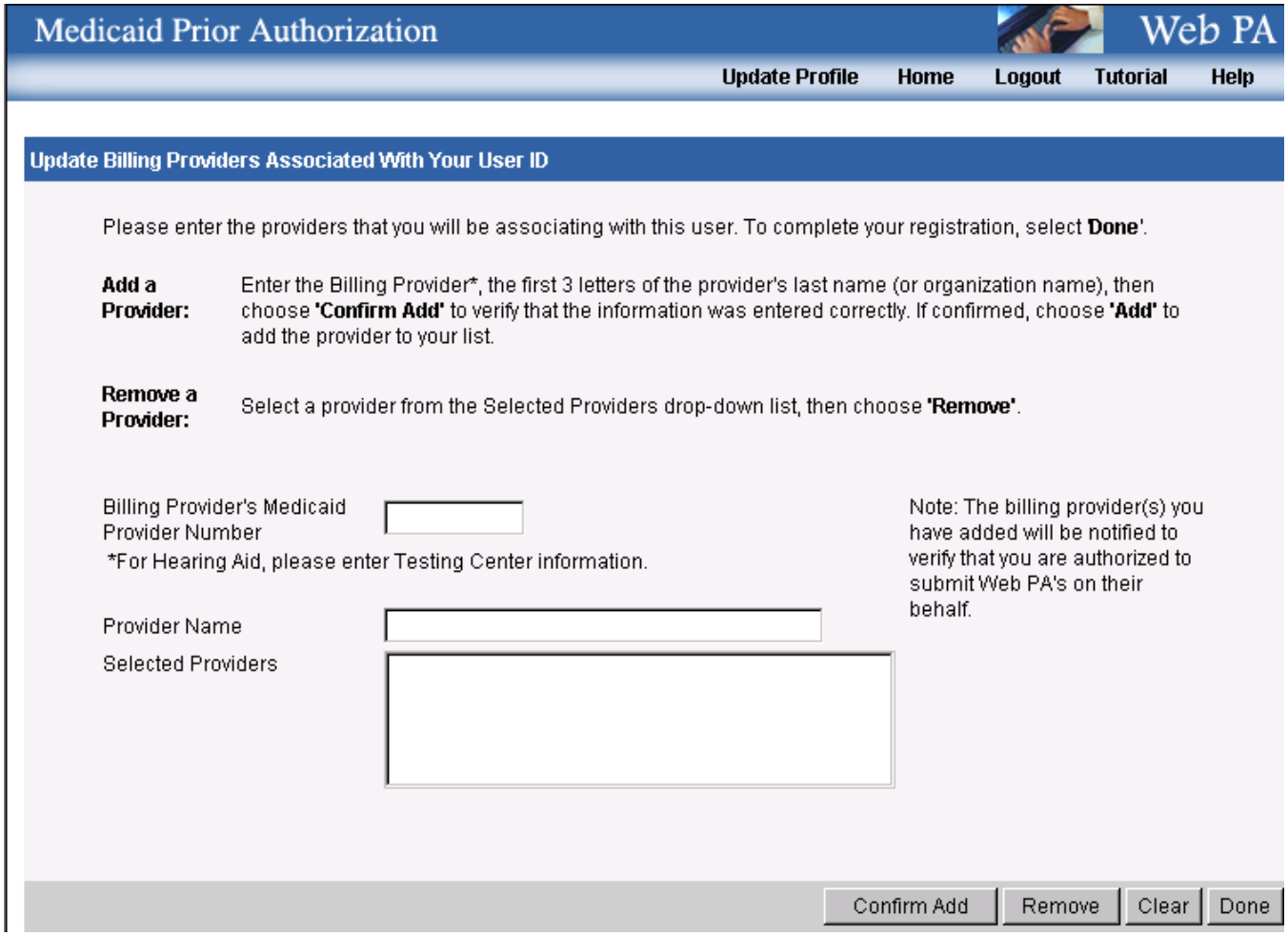
For processing types 111, 112, 113, 118, 120, 121, 126, 127, 128, 129, 135, 136, and 999: Users may only submit the Prior Authorization Request Form (PA Request) via the Web. Users will then be required to print the PA Request and mail or fax the entire PA request, which includes the PA Request from the Web, service-specific PA attachments, and any supporting clinical documentation, to Wisconsin Medicaid.

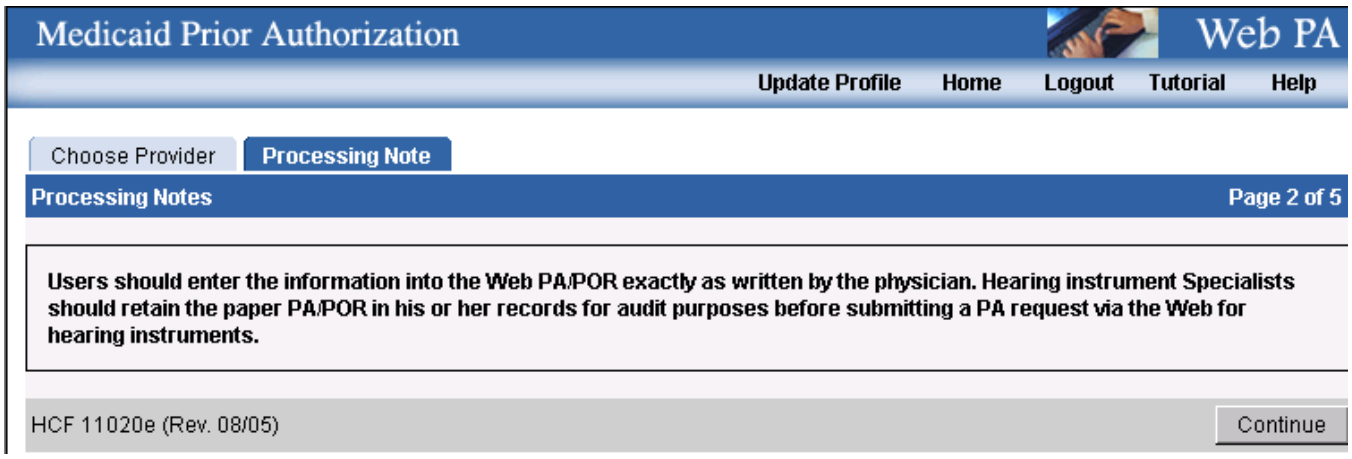
For processing types 114, 115, 116, 117, 122, 130, 132, 139, 140: Users have two submission options for submitting PA requests via the Web. If a user has no supporting clinical documentation, submit the PA request via the Web by completing the PA Request and service-specific PA attachments. If supporting clinical documentation is included with the PA request, complete the PA Request and service-specific PA attachments via the Web and then send the PA Request, service-specific PA attachments, and any supporting clinical documentation on paper by mail or fax.

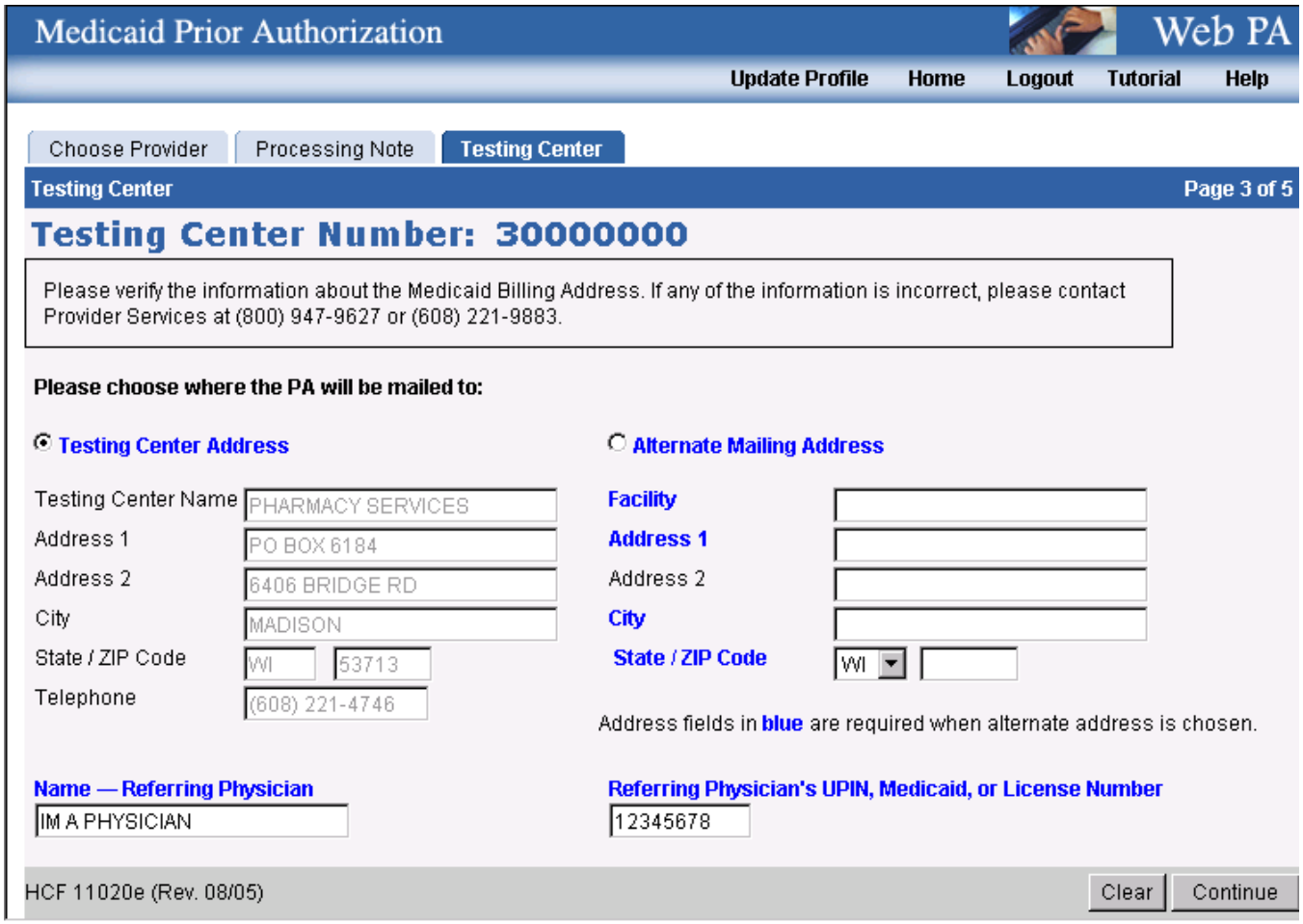
For process type 123: Users have two submission options for submitting PA requests via the Web. If a user has no supporting clinical documentation, submit the PA request via the Web by completing the Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) and service-specific PA attachments. If supporting clinical documentation is included with the PA request, complete the PA/HIAS1 and service-specific PA attachments via the Web and then send the PA/HIAS1, service-specific PA attachments, and any supporting clinical documentation on paper by mail or fax.

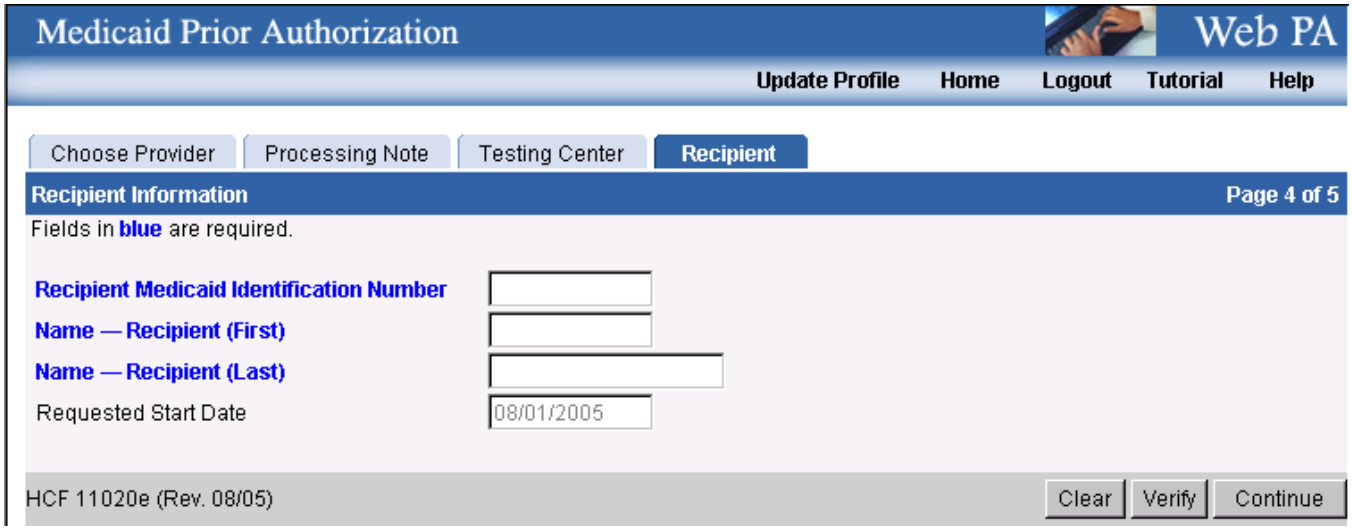
For process types 160, 161, and 162: Users may only submit the PA Request and the service specific attachment via the Web. If supporting clinical documentation is included with the PA request, the PA request cannot be completed or submitted via the Web.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

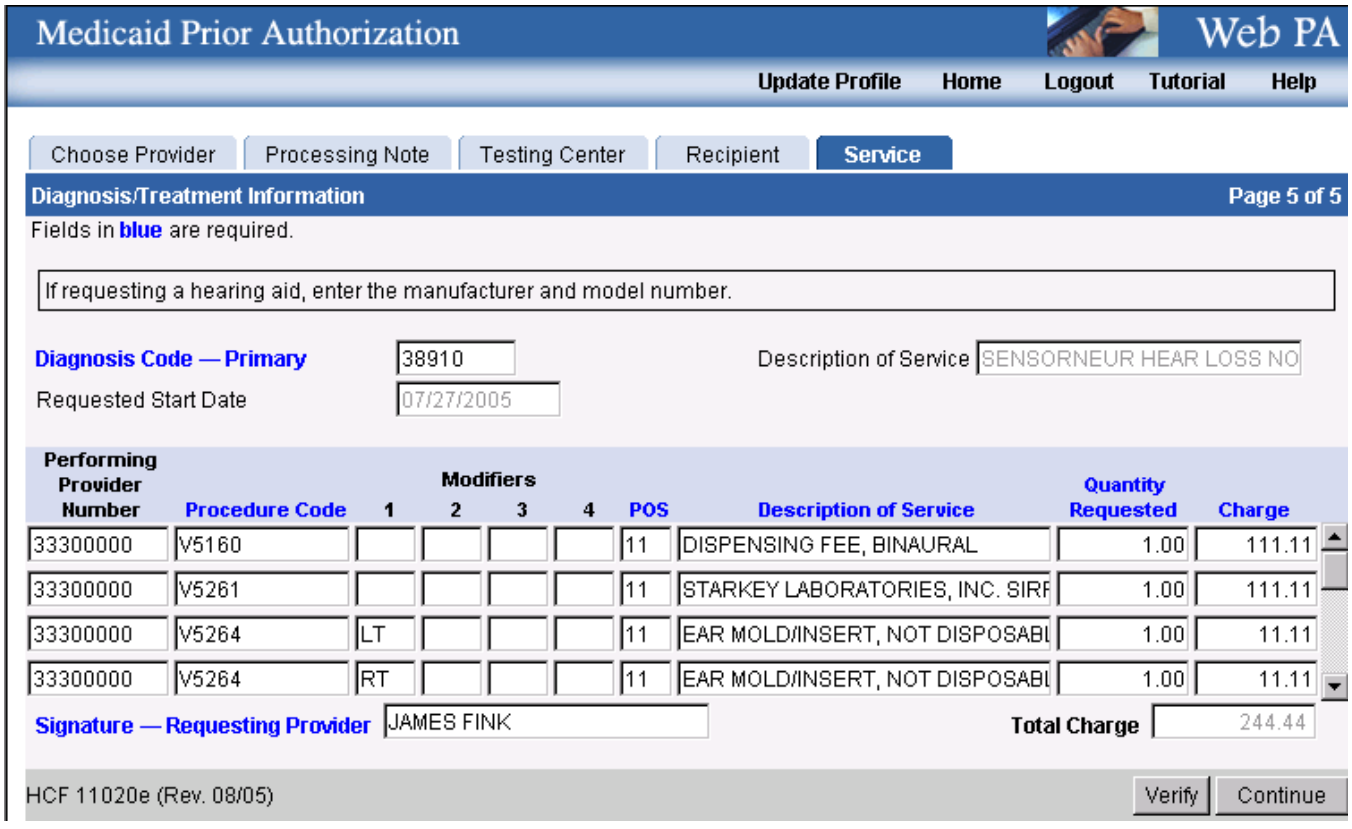

Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Update Billing Providers Associated With Your User ID
Please enter the providers that you will be associating with this user. To complete your registration, select 'Done'.
Add a Provider:
Enter the Billing Provider*, the first 3 letters of the provider's last name (or organization name), then choose 'Confirm Add' to verify that the information was entered correctly. If confirmed, choose 'Add' to add the provider to your list.
Remove a Provider:
Select a provider from the Selected Providers drop-down list, then choose 'Remove'.
Billing Provider's Medicaid Provider Number
*For Hearing Aid, please enter Testing Center information.
Provider Name
Selected Providers
Note: The billing provider(s) you have added will be notified to verify that you are authorized to submit Web PA's on their behalf.
Confirm Add
Remove
Clear
Done

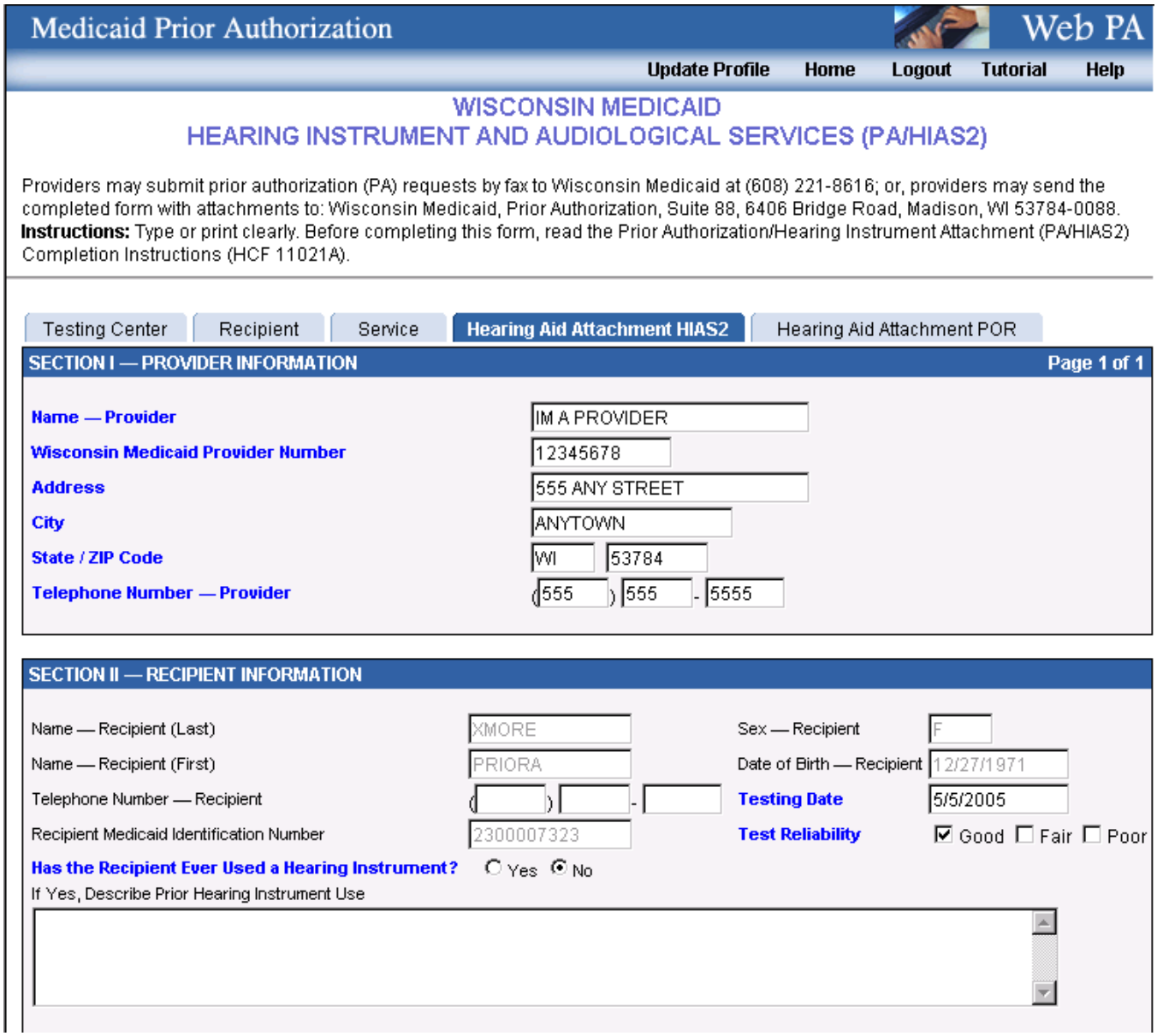

Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Choose Provider
Processing Note
Processing Notes
Page 2 of 5
Users should enter the information into the Web PA/POR exactly as written by the physician. Hearing instrument Specialists should retain the paper PA/POR in his or her records for audit purposes before submitting a PA request via the Web for hearing instruments.
HCF 11020e (Rev. 08/05)
Continue

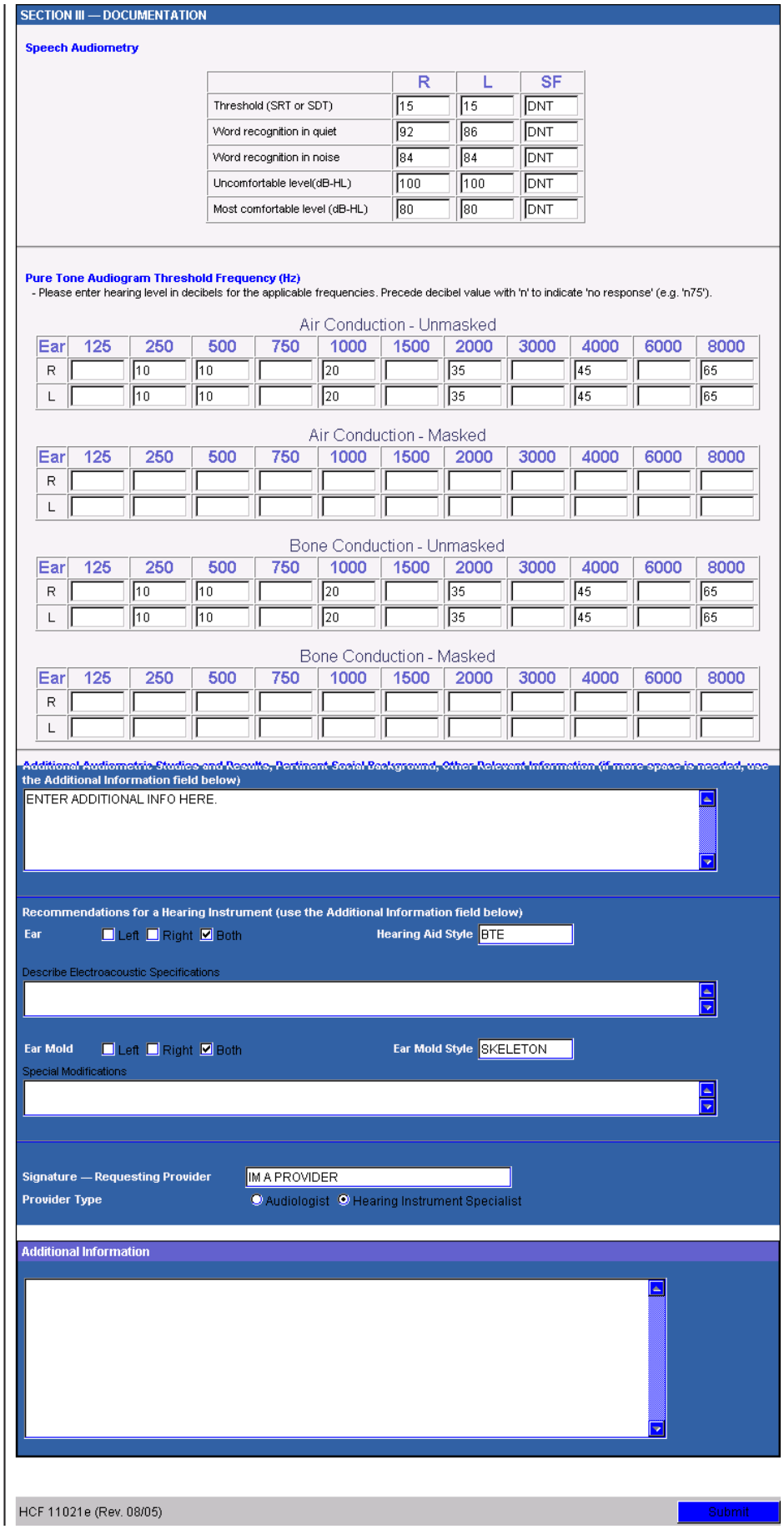

Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Choose Provider
Processing Note
Testing Center
Testing Center
Page 3 of 5
Testing Center Number: 30000000
Please verify the information about the Medicaid Billing Address. If any of the information is incorrect, please contact Provider Services at (800) 947-9627 or (608) 221-9883.
Please choose where the PA will be mailed to:
Testing Center Address
Testing Center Name
PHARMACY SERVICES
Address 1
PO BOX 6184
Address 2
6406 BRIDGE RD
City
MADISON
State / ZIP Code
WI
53713
Telephone
(608) 221-4746
Alternate Mailing Address
Facility
Address 1
Address 2
City
State / ZIP Code
WI
Address fields in blue are required when alternate address is chosen.
Name — Referring Physician
IM A PHYSICIAN
Referring Physician's UPIN, Medicaid, or License Number
12345678
HCF 11020e (Rev. 08/05)
Clear
Continue


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Choose Provider
Processing Note
Testing Center
Recipient
Recipient Information
Page 4 of 5
Fields in blue are required.
Recipient Medicaid Identification Number
Name — Recipient (First)
Name — Recipient (Last)
Requested Start Date
08/01/2005
HCF 11020e (Rev. 08/05)
Clear
Verify
Continue


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Choose Provider
Processing Note
Testing Center
Recipient
Recipient Information
Page 4 of 5
Fields in blue are required.
Recipient Medicaid Identification Number
2300007323
Name — Recipient (First)
PRIORA
Name — Recipient (Last)
XMORE
Requested Start Date
07/25/2005
Date of Birth
12/27/1971
Address
PRIOR LESS 2000
City
MADISON
State
WI
ZIP Code
53704
Sex — Recipient
F
Please verify the information about the Medicaid Recipient you entered. If any of the information is incorrect, please inform the recipient that they need to contact their case-worker to resolve any discrepancies.
HCF 11020e (Rev. 08/05)
Clear
Verify
Continue


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Choose Provider
Processing Note
Testing Center
Recipient
Service
Diagnosis/Treatment Information
Page 5 of 5
Fields in blue are required.
If requesting a hearing aid, enter the manufacturer and model number.
Diagnosis Code — Primary
38910
Description of Service
SENSORNEUR HEAR LOSS NO
Requested Start Date
07/27/2005
Performing Provider Number
Procedure Code
Modifiers 1 2 3 4
POS
Description of Service
Quantity Requested
Charge
33300000 V5160 11 DISPENSING FEE, BINAURAL 1.00 111.11
33300000 V5261 11 STARKEY LABORATORIES, INC. SIRI 1.00 111.11
33300000 V5264 LT 11 EAR MOLD/INSERT, NOT DISPOSABL 1.00 11.11
33300000 V5264 RT 11 EAR MOLD/INSERT, NOT DISPOSABL 1.00 11.11
Signature — Requesting Provider
JAMES FINK
Total Charge
244.44
HCF 11020e (Rev. 08/05)
Verify
Continue


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
WISCONSIN MEDICAID
HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2)
Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Hearing Instrument Attachment (PA/HIAS2) Completion Instructions (HCF 11021A).
Testing Center
Recipient
Service
Hearing Aid Attachment HIAS2
Hearing Aid Attachment POR
SECTION I — PROVIDER INFORMATION
Page 1 of 1
Name — Provider
IM A PROVIDER
Wisconsin Medicaid Provider Number
12345678
Address
555 ANY STREET
City
ANYTOWN
State / ZIP Code
WI
53784
Telephone Number — Provider
555
555
5555
SECTION II — RECIPIENT INFORMATION
Name — Recipient (Last)
XMORE
Name — Recipient (First)
PRIORA
Telephone Number — Recipient
Recipient Medicaid Identification Number
2300007323
Has the Recipient Ever Used a Hearing Instrument?
Yes
No
If Yes, Describe Prior Hearing Instrument Use
Sex — Recipient
F
Date of Birth — Recipient
12/27/1971
Testing Date
5/5/2005
Test Reliability
Good
Fair
Poor



SECTION III — DOCUMENTATION

**Speech Audiometry**

| | R | L | SF |
|---|---|---|---|
| Threshold (SRT or SDT) | 15 | 15 | DNT |
| Word recognition in quiet | 92 | 86 | DNT |
| Word recognition in noise | 84 | 84 | DNT |
| Uncomfortable level(dB-HL) | 100 | 100 | DNT |
| Most comfortable level (dB-HL) | 80 | 80 | DNT |

**Pure Tone Audiogram Threshold Frequency (Hz)**

- Please enter hearing level in decibels for the applicable frequencies. Precede decibel value with 'n' to indicate 'no response' (e.g. 'n75').

Air Conduction - Unmasked

| Ear | 125 | 250 | 500 | 750 | 1000 | 1500 | 2000 | 3000 | 4000 | 6000 | 8000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| R | | 10 | 10 | | 20 | | 35 | | 45 | | 65 |
| L | | 10 | 10 | | 20 | | 35 | | 45 | | 65 |

Air Conduction - Masked

| Ear | 125 | 250 | 500 | 750 | 1000 | 1500 | 2000 | 3000 | 4000 | 6000 | 8000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| R | | | | | | | | | | | |
| L | | | | | | | | | | | |

Bone Conduction - Unmasked

| Ear | 125 | 250 | 500 | 750 | 1000 | 1500 | 2000 | 3000 | 4000 | 6000 | 8000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| R | | 10 | 10 | | 20 | | 35 | | 45 | | 65 |
| L | | 10 | 10 | | 20 | | 35 | | 45 | | 65 |

Bone Conduction - Masked

| Ear | 125 | 250 | 500 | 750 | 1000 | 1500 | 2000 | 3000 | 4000 | 6000 | 8000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| R | | | | | | | | | | | |
| L | | | | | | | | | | | |

**Additional Audiometric Studies and Results, Pertinent Social Background, Other Relevant Information (if more space is needed, use the Additional Information field below)**

ENTER ADDITIONAL INFO HERE.

**Recommendations for a Hearing Instrument (use the Additional Information field below)**

**Ear** ☐ Left ☐ Right ☑ Both **Hearing Aid Style** BTE

Describe Electroacoustic Specifications

**Ear Mold** ☐ Left ☐ Right ☑ Both **Ear Mold Style** SKELETON

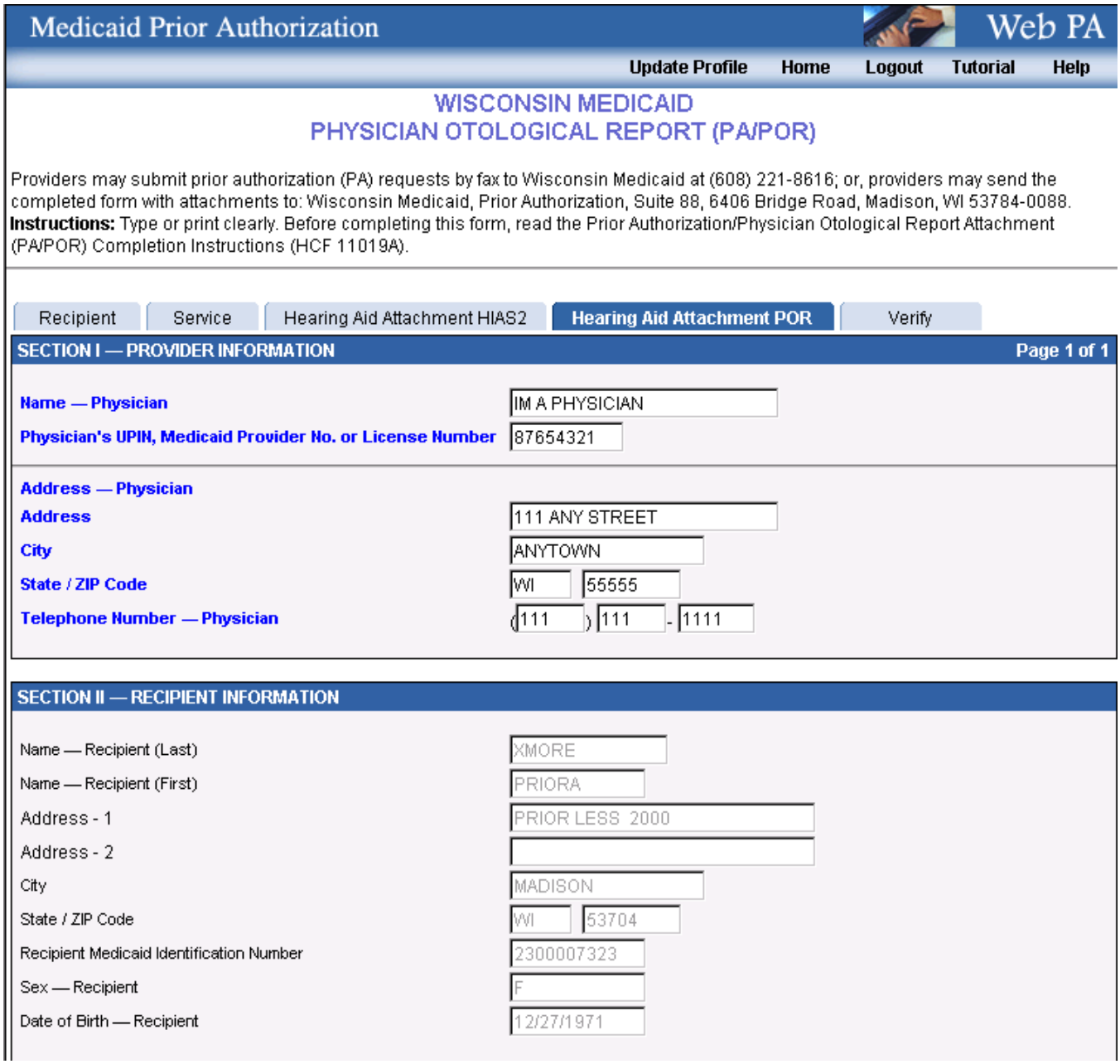
Special Modifications

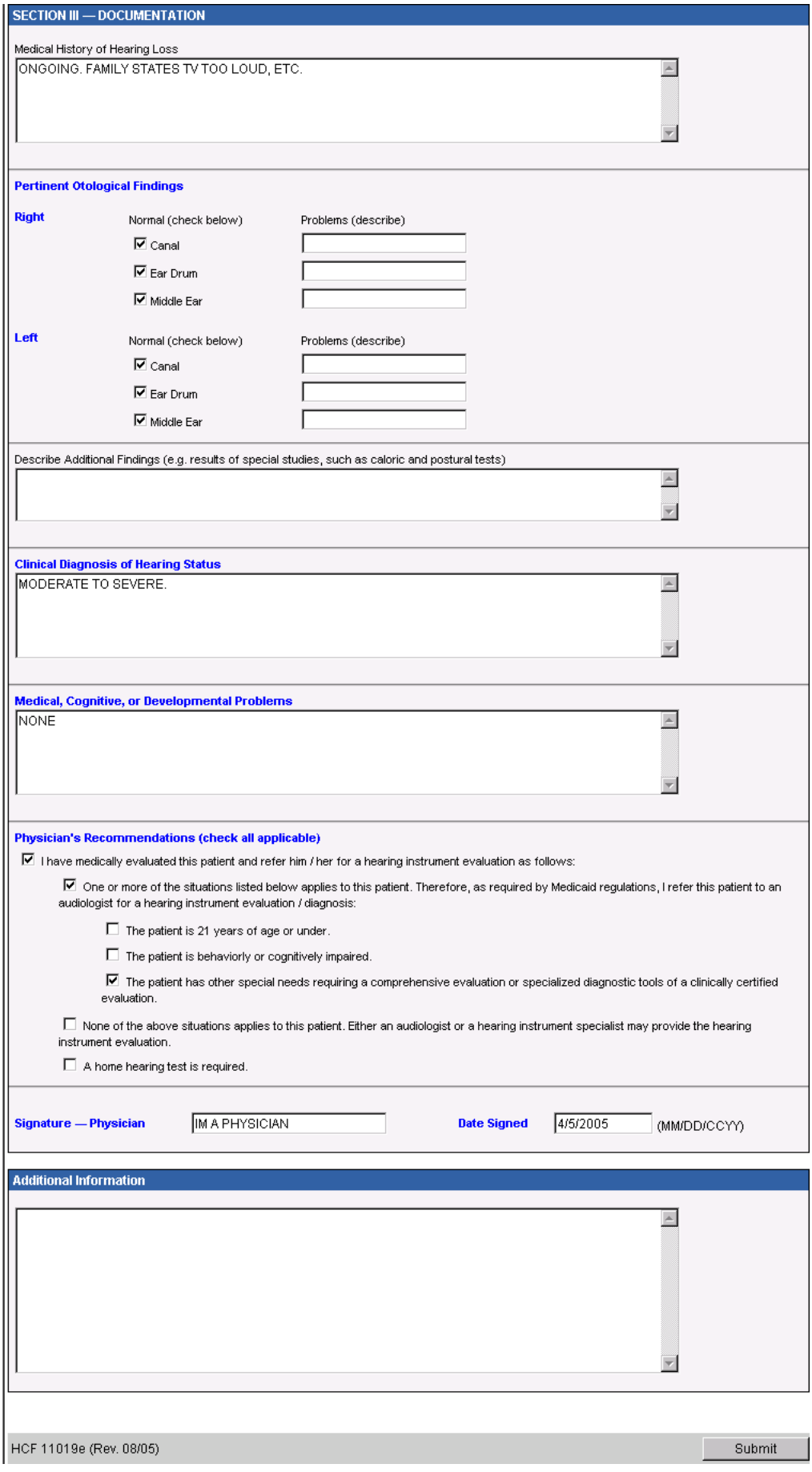
**Signature — Requesting Provider** IM A PROVIDER

**Provider Type** ○ Audiologist ◉ Hearing Instrument Specialist

**Additional Information**

HCF 11021e (Rev. 08/05) Submit


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
WISCONSIN MEDICAID
PHYSICIAN OTOLOGICAL REPORT (PA/POR)
Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Physician Otological Report Attachment (PA/POR) Completion Instructions (HCF 11019A).
Recipient
Service
Hearing Aid Attachment HIAS2
Hearing Aid Attachment POR
Verify
SECTION I — PROVIDER INFORMATION
Page 1 of 1
Name — Physician
IM A PHYSICIAN
Physician's UPIN, Medicaid Provider No. or License Number
87654321
Address — Physician
Address
111 ANY STREET
City
ANYTOWN
State / ZIP Code
WI
55555
Telephone Number — Physician
(111) 111 - 1111
SECTION II — RECIPIENT INFORMATION
Name — Recipient (Last)
XMORE
Name — Recipient (First)
PRIORA
Address - 1
PRIOR LESS 2000
Address - 2
City
MADISON
State / ZIP Code
WI
53704
Recipient Medicaid Identification Number
2300007323
Sex — Recipient
F
Date of Birth — Recipient
12/27/1971



SECTION III — DOCUMENTATION

Medical History of Hearing Loss

ONGOING. FAMILY STATES TV TOO LOUD, ETC.

**Pertinent Otological Findings**

**Right**

| Normal (check below) | Problems (describe) |
|---|---|
| ☑ Canal | |
| ☑ Ear Drum | |
| ☑ Middle Ear | |

**Left**

| Normal (check below) | Problems (describe) |
|---|---|
| ☑ Canal | |
| ☑ Ear Drum | |
| ☑ Middle Ear | |

Describe Additional Findings (e.g. results of special studies, such as caloric and postural tests)

**Clinical Diagnosis of Hearing Status**

MODERATE TO SEVERE.

**Medical, Cognitive, or Developmental Problems**

NONE

**Physician's Recommendations (check all applicable)**

☑ I have medically evaluated this patient and refer him / her for a hearing instrument evaluation as follows:

☑ One or more of the situations listed below applies to this patient. Therefore, as required by Medicaid regulations, I refer this patient to an audiologist for a hearing instrument evaluation / diagnosis:

- ☐ The patient is 21 years of age or under.
- ☐ The patient is behaviorly or cognitively impaired.
- ☑ The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.

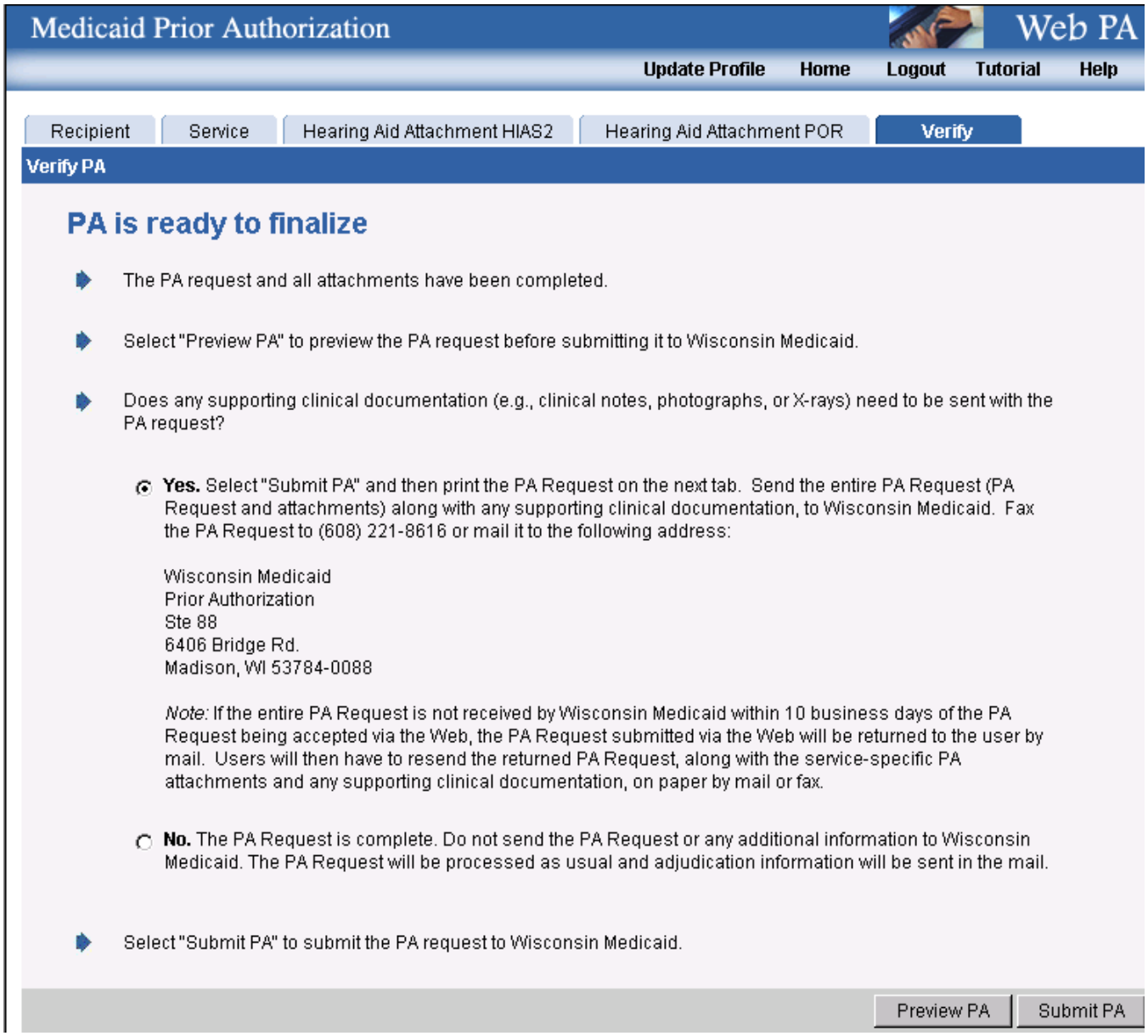
☐ None of the above situations applies to this patient. Either an audiologist or a hearing instrument specialist may provide the hearing instrument evaluation.

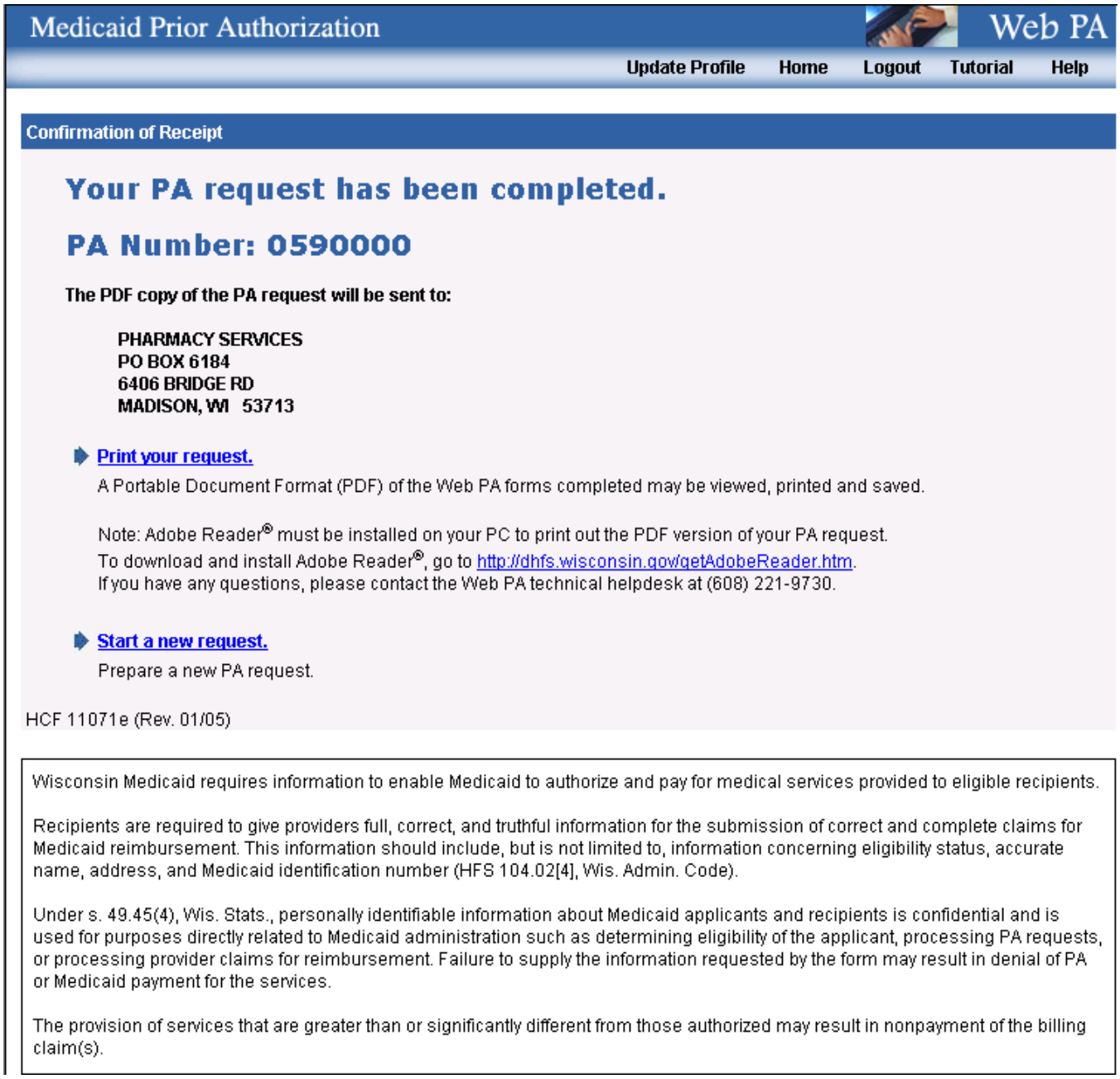
☐ A home hearing test is required.

**Signature — Physician** IM A PHYSICIAN **Date Signed** 4/5/2005 (MM/DD/CCYY)

**Additional Information**

HCF 11019e (Rev. 08/05) Submit


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Recipient
Service
Hearing Aid Attachment HIAS2
Hearing Aid Attachment POR
Verify
Verify PA
PA is ready to finalize
The PA request and all attachments have been completed.
Select "Preview PA" to preview the PA request before submitting it to Wisconsin Medicaid.
Does any supporting clinical documentation (e.g., clinical notes, photographs, or X-rays) need to be sent with the PA request?
Yes. Select "Submit PA" and then print the PA Request on the next tab. Send the entire PA Request (PA Request and attachments) along with any supporting clinical documentation, to Wisconsin Medicaid. Fax the PA Request to (608) 221-8616 or mail it to the following address:
Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd.
Madison, WI 53784-0088
Note: If the entire PA Request is not received by Wisconsin Medicaid within 10 business days of the PA Request being accepted via the Web, the PA Request submitted via the Web will be returned to the user by mail. Users will then have to resend the returned PA Request, along with the service-specific PA attachments and any supporting clinical documentation, on paper by mail or fax.
No. The PA Request is complete. Do not send the PA Request or any additional information to Wisconsin Medicaid. The PA Request will be processed as usual and adjudication information will be sent in the mail.
Select "Submit PA" to submit the PA request to Wisconsin Medicaid.
Preview PA
Submit PA


Medicaid Prior Authorization
Web PA
Update Profile
Home
Logout
Tutorial
Help
Confirmation of Receipt
Your PA request has been completed.
PA Number: 0590000
The PDF copy of the PA request will be sent to:
PHARMACY SERVICES
PO BOX 6184
6406 BRIDGE RD
MADISON, WI 53713
Print your request.
A Portable Document Format (PDF) of the Web PA forms completed may be viewed, printed and saved.
Note: Adobe Reader® must be installed on your PC to print out the PDF version of your PA request.
To download and install Adobe Reader®, go to http://dhfs.wisconsin.gov/getAdobeReader.htm.
If you have any questions, please contact the Web PA technical helpdesk at (608) 221-9730.
Start a new request.
Prepare a new PA request.
HCF 11071e (Rev. 01/05)
Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.
Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).
Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.
The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 11020 (Rev. 08/05)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code


**WISCONSIN MEDICAID**

# PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to:
Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the instructions and information published in HCF 11020A.

**FOR MEDICAID USE**
- [X] Web PA Additional Information Required
- [ ] Web PA Returned Additional Information Needed

| FOR MEDICAID USE -ICN | AT | Prior Authorization Number |
|---|---|---|
| 24922005208223000 | A | 0590000 |

## SECTION I - PROVIDER INFORMATION

| 1. Name and Address - Testing Center (Street, City, State, Zip Code) | 2. Telephone Number - Testing Center | 3. Processing Type |
|---|---|---|
| PHARMACY SERVICES<br>PO BOX 6184<br>6406 BRIDGE RD<br>MADISON, WI 53713 | (608) 221-4746 | 123 |
| | 4. Testing Center's Medicaid Provider Number: 30000000 | |
| 5. Name - Referring Physician: IM A PHYSICIAN | 6. Referring Physician's UPIN, Medicaid, or License Number: 12345678 | |

## SECTION II - RECIPIENT INFORMATION

| 7. Name and Address - Recipient (Last, First, Middle Initial; Street, City, State, Zip Code) | 8. Recipient Medicaid ID Number | 9. Sex - Recipient |
|---|---|---|
| XMORE,PRIORA<br>PRIOR LESS 2000<br>MADISON, WI 53704 | 2300007323 | [ ] M<br>[X] F |
| | 10. Date of Birth - Recipient(MM/DD/YY): 12/27/1971 | |

## SECTION III- DIAGNOSIS/TREATMENT INFORMATION

11. Diagnosis - Code and Description
38910 - SENSORINEUR HEAR LOSS NOS

| 12. Performing Provider Number | 13. Procedure Code | 14. Modifiers 1 | 2 | 3 | 4 | 15. POS | 16. Description of Service | 17. QR | 18. Charge |
|---|---|---|---|---|---|---|---|---|---|
| 33300000 | V5160 | | | | | 11 | DISPENSING FEE, BINAURAL | 1.00 | $111.11 |
| 33300000 | V5261 | | | | | 11 | STARKEY LABORATORIES, INC. SIRRUS 11 BINAURAL DIGITAL HEARING AID | 1.00 | $111.11 |

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

**19. Total Charges**: $244.44

| 20. SIGNATURE - Requesting Provider | 21. Provider Type | 22. Date Signed |
|---|---|---|
| JAMES FINK | [ ] Audiologist<br>[X] Hearing Instrument Specialist | 07/27/2005 |

**FOR MEDICAID USE**

Procedure(s) Authorized: Quantity Authorized:

- [ ] Approved — Grant Date: _____ Expiration Date: _____
- [ ] Modified - Reason:
- [ ] Denied - Reason:
- [ ] Returned - Reason:

SIGNATURE - Consultant / Analyst: _____ Date Signed: _____

24922005208223000

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 11020 (Rev. 08/05)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code


**WISCONSIN MEDICAID**

# PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to:
Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the instructions and information published in HCF 11020A.

**FOR MEDICAID USE**
[X] Web PA Additional Information Required
[ ] Web PA Returned Additional Information Needed

| FOR MEDICAID USE -ICN | AT | Prior Authorization Number |
|---|---|---|
| 24922005208223000 | A | 0590000 |

## SECTION I - PROVIDER INFORMATION

| 1. Name and Address - Testing Center (Street, City, State, Zip Code) | 2. Telephone Number - Testing Center | 3. Processing Type |
|---|---|---|
| PHARMACY SERVICES<br>PO BOX 6184<br>6406 BRIDGE RD<br>MADISON, WI 53713 | (608) 221-4746 | 123 |
| | 4. Testing Center's Medicaid Provider Number: 30000000 | |
| 5. Name - Referring Physician: IM A PHYSICIAN | 6. Referring Physician's UPIN, Medicaid, or License Number: 12345678 | |

## SECTION II - RECIPIENT INFORMATION

| 7. Name and Address - Recipient (Last, First, Middle Initial; Street, City, State, Zip Code) | 8. Recipient Medicaid ID Number | 9. Sex - Recipient |
|---|---|---|
| XMORE,PRIORA<br>PRIOR LESS 2000<br>MADISON, WI 53704 | 2300007323 | [ ] M<br>[X] F |
| | 10. Date of Birth - Recipient(MM/DD/YY): 12/27/1971 | |

## SECTION III- DIAGNOSIS/TREATMENT INFORMATION

11. Diagnosis - Code and Description
38910 - SENSORINEUR HEAR LOSS NOS

| 12. Performing Provider Number | 13. Procedure Code | 14. Modifiers 1 | 2 | 3 | 4 | 15. POS | 16. Description of Service | 17. QR | 18. Charge |
|---|---|---|---|---|---|---|---|---|---|
| 33300000 | V5264 | LT | | | | 11 | EAR MOLD/INSERT, NOT DISPOSABLE, ANY TYPE | 1.00 | $11.11 |
| 33300000 | V5264 | RT | | | | 11 | EAR MOLD/INSERT, NOT DISPOSABLE, ANY TYPE | 1.00 | $11.11 |

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

**19. Total Charges**: $244.44

| 20. SIGNATURE - Requesting Provider | 21. Provider Type | 22. Date Signed |
|---|---|---|
| JAMES FINK | [ ] Audiologist<br>[X] Hearing Instrument Specialist | 07/27/2005 |

**FOR MEDICAID USE**

Procedure(s) Authorized: Quantity Authorized:

[ ] Approved _____ (Grant Date) _____ (Expiration Date)

[ ] Modified - Reason:

[ ] Denied - Reason:

[ ] Returned - Reason:

_____ SIGNATURE - Consultant / Analyst _____ Date Signed

24922005208223000

# WISCONSIN MEDICAID
# PRIOR AUTHORIZATION REQUEST / HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. Instructions: Type or print clearly. Before completing this form, read the PA/HIAS2 Completion Instructions (HCF 11021A).

## SECTION I - PROVIDER INFORMATION

| 1. Name - Provider | 4. Address - Provider |
|---|---|
| IM A PROVIDER | 555 ANY STREET<br>ANYTOWN, WI 53784 |
| 2. Wisconsin Medicaid Provider Number<br>12345678 | |
| 3. Telephone Number - Provider<br>(555) 555-5555 | |

## SECTION II - RECIPIENT INFORMATION

| 5. Name - Recipient (Last, First, Middle Initial) | 6. Date of Birth - Recipient | 7. Telephone Number - Recipient |
|---|---|---|
| XMORE, PRIORA | 12/27/1971 | () - |
| 8. Recipient Medicaid Identification Number<br>2300007323 | 9. Sex - Recipient<br>☐ Male ☒ Female | 10. Prior Hearing Instrument Use?<br>☐ Yes ☒ No |
| 11. Describe Prior Hearing Instrument Use | 12. Testing Date<br>5/5/2005 | 13. Test Reliability<br>☒ Good ☐ Fair ☐ Poor |

## SECTION III - DOCUMENTATION

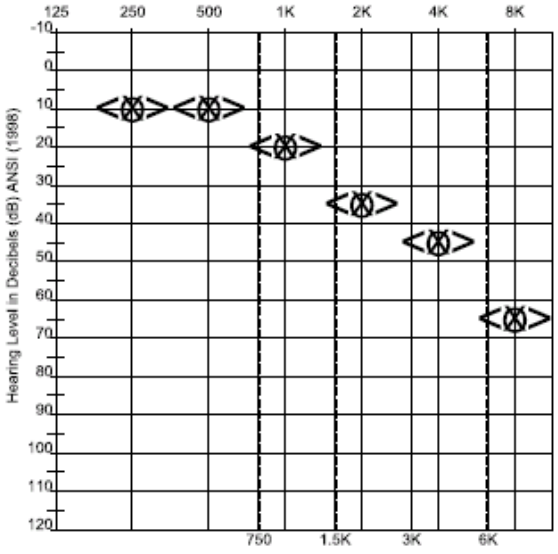
14.

Legend

| Ear | Air: Un masked | Air: Masked | Bone: Un masked | Bone: Masked | NR |
|---|---|---|---|---|---|
| Right | O | △ | < | [ | ⌞ |
| Left | X | □ | > | ] | ⌟ |

| SPEECH AUDIOMETRY | R | L | SF |
|---|---|---|---|
| Threshold (SRT or SDT) | 15 | 15 | DNT |
| Word recognition in quiet | 92 | 86 | DNT |
| Word recognition in noise | 84 | 84 | DNT |
| Uncomfortable level (dB-HL) | 100 | 100 | DNT |
| Most comfortable level (dB-HL) | 80 | 80 | DNT |

15. Pure Tone Audiogram - Frequency in Hertz (Hz)




16. Additional Audiometric Studies and Results, Pertinent Social Background, Other Relevant Information (use attachment if necessary)
ENTER ADDITIONAL INFO HERE.

17. Recommendations for a Hearing Instrument (use an attachment if necessary)

Ear (check one) ☐ Left ☐ Right ☒ Both

Ear Mold Style SKELETON Hearing Aid Style BTE

Describe Electroacoustic Specifications

Ear Mold ☐ Left ☐ Right ☒ Both

Special Modifications

| 18. Signature - Requesting Provider | 20. Provider Type | 21. Date Signed |
|---|---|---|
| IM A PROVIDER | ☐ Audiologist<br>☒ Hearing Instrument Specialist | 07/27/2005 |

**Additional Information**

# WISCONSIN MEDICAID
# PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Physician Otological Report (PA/POR) Completion Instructions (HCF 11019A).

**SECTION I - PROVIDER INFORMATION**

| 1. Name - Physician | 2. Physicians UPIN, Medical Provider Number, or License Number |
|---|---|
| IM A PHYSICIAN | 87654321 |
| **3. Address - Physician** | **4. Telephone Number - Physician** |
| 111 ANY STREET<br>ANYTOWN , WI 55555 | (111) 111-1111 |

**SECTION II - RECIPIENT INFORMATION**

| 5. Name - Recipient (Last, First, Middle Initial) | 6. Date of Birth - Recipient |
|---|---|
| XMORE, PRIORA | 12/27/1971 |

7. Address - Recipient
PRIOR LESS 2000
MADISON, WI 53704

| 8. Recipient Medicaid Identification Number | 9. Sex - Recipient |
|---|---|
| 2300007323 | ☐ Male ☒ Female |

**SECTION III - DOCUMENTATION**

10. Medical History of Hearing Loss
ONGOING. FAMILY STATES TV TOO LOUD, ETC.

11. Pertinent Otological Findings

| | | Normal | Problems |
|---|---|---|---|
| Right: | Canal | ☒ | |
| | Ear Drum | ☒ | |
| | Middle Ear | ☒ | |
| Left: | Canal | ☒ | |
| | Ear Drum | ☒ | |
| | Middle Ear | ☒ | |

12. Describe Additional Findings (e.g., results of special studies, such as caloric and postural tests)

13. Clinical Diagnosis of Hearing Status
MODERATE TO SEVERE.

14. Medical, Cognitive, or Developmental Problems
NONE

15. Physicians Recommendations

☒ I have medically evaluated this patient and refer him / her for a hearing instrument evaluation as follows:

☒ One or more of the situations listed below applies to this patient. Therefore, as required by Medicaid regulations, I refer this patient to an audiologist for a hearing instrument evaluation / diagnosis:

- ☐ The patient is 21 years of age or under.
- ☐ The patient is behaviorly or cognitively impaired.
- ☒ The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.

☐ None of the above situations applies to this patient. Either an audiologist or a hearing instrument specialist may provide the hearing instrument evaluation.

☐ A home hearing test is required.

| Signature - Physician | Date Signed |
|---|---|
| IM A PHYSICIAN | 4/5/2005 |

**Additional Information**